Registration Form
for Reporting of Health Care Claims Data
to the Commonwealth of Massachusetts
Health Care Quality and Cost Council
For Submission of Data to the Maine Health Information Center

Fax registration form by October 26, 2007 to: Data Manager (207) 622-7086

Company Name: _____

NAIC: _____

Mailing Address: _____

_____

_____

1. Does your company currently issue or renew insured health coverage in the Commonwealth of Massachusetts?

   _____ Yes _____ No (Skip to #8)

   1a) Are you a CARRIER that covers a total of **2,000 or more** Massachusetts resident covered lives?

   _____ Yes Initial data set due December 1, 2007 for the period of July 1, 2006 through September 30, 2007.

   _____ No

   1b) Are you a CARRIER that covers **fewer than 2,000** Massachusetts resident covered lives?

   _____ Yes Initial data set due June 1, 2008 for the period of January 1, 2008 through March 31, 2008.

   _____ No

   1c) Are you a CARRIER that provides **stand-alone insured dental coverage**?

   _____ Yes Initial data set due September 1, 2008 for the period of July 1, 2007 through June 30, 2008.

   _____No

2. Please complete information below regarding the <u>eligibility data</u> your company will be submitting.

   Estimated # Total Massachusetts Resident Covered Lives for 1 Month: _____

   Estimated # Medicare Supplemental Massachusetts Resident Covered Lives in 1 Month: _____

   Contact Name: _____ Phone: _____

   Email Address: _____ Fax: _____

   Company Name: _____

   Mailing Address: _____

   _____

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3. Will your company be submitting medical claims data? __ Yes ___ No (Skip to #4)

   Contact Name: _____ Phone: _____

   Email Address: _____ Fax: _____

   Company Name: _____

   Mailing Address: _____

   _____

4. Will your company be submitting pharmacy claims data? __ Yes ___ No (Skip to #5)

   Contact Name: _____ Phone: _____

   Email Address: _____ Fax: _____

   Company Name: _____

   Mailing Address: _____

   _____

5. Will your company be submitting dental claims data? __ Yes ___ No (Skip to #6)

   Contact Name: _____ Phone: _____

   Email Address: _____ Fax: _____

   Company Name: _____

   Mailing Address: _____

   _____

6. Does your company generate HEDIS summary information for NCQA? ___Yes ___No

   If yes, provide contact information below.

   Contact Name: _____ Phone: _____

   Email Address: _____ Fax: _____

   Company Name: _____

   Mailing Address: _____

   _____

7. Does your company generate CAHPS information for NCQA? ___Yes ___No

   If yes, provide contact information below.

   Contact Name: _____ Phone: _____

   Email Address: _____ Fax: _____

   Company Name: _____

   Mailing Address: _____

   _____

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8. Person completing form:

   Contact Name: _____ Phone: _____

   Email Address: _____ Fax: _____

   Company Name: _____

   Mailing Address: _____

   _____

9. Is the person completing this form the compliance contact? ___Yes ___No

   If no, provide legal/compliance contact information below.

   Contact Name: _____ Phone: _____

   Email Address: _____ Fax: _____

   Company Name: _____

   Mailing Address: _____

   _____

   Date Completed: _____

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Questions: Gloria McCann, Data Manager
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Telephone: (207) 430-0642